SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Filing at a Glance

Company: Everest National Insurance Company

Product Name: A&H	SERFF Tr Num: EVST-125727629	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 39559
Sub-TOI: H21.000 Health - Other	Co Tr Num: AR-AH-20024410-EN	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Vanessa King	Disposition Date: 07/09/2008
	Date Submitted: 07/09/2008	Disposition Status: Approved-Closed

Implementation Date Requested: 08/01/2008

Implementation Date:

State Filing Description:

General Information

Project Name: Excess Loss Schedule	Status of Filing in Domicile: Not Filed
Project Number: AR-AH-20024410	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type:	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/09/2008	
State Status Changed: 07/09/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We are filing for approval an Excess Loss Schedule, EDEC 642 04 08.

Company and Contact

Filing Contact Information

Vanessa King, Manager, Filing and Regulation	vanessa.king@everestre.com
P.O. Box 830	(908) 604-3267 [Phone]

SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Liberty Corner, NJ 07938-0830 (908) 604-3546[FAX]

Filing Company Information

Everest National Insurance Company	CoCode: 10120	State of Domicile: Delaware
477 Martinsville Road	Group Code: 1120	Company Type:
P.O. Box 830		
Liberty Corner, NJ 07938-0830	Group Name: Everest Re Group, Ltd.	State ID Number:
(908) 604-3000 ext. [Phone]	FEIN Number: 22-2660372	

SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Everest National Insurance Company	$50.00	07/09/2008	21316499

SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/09/2008	07/09/2008

SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Disposition

Disposition Date: 07/09/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	EXCESS LOSS SCHEDULE	Approved-Closed	Yes

SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Form Schedule

Lead Form Number: EDEC 642 04 08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	EDEC 642 04 08	Schedule Pages	EXCESS LOSS SCHEDULE	Initial			EDEC 642 04 08 _AR_.pdf

❑ **EVEREST NATIONAL INSURANCE COMPANY**
❑ **EVEREST REINSURANCE COMPANY**
(hereinafter referred to as "we", "us", "our")
Excess Loss Insurance is offered by the entity checked above

Westgate Corporate Center
477 Martinsville Road
P.O. Box 830
Liberty Corner, NJ 07938-0830
(800) 438-4375

EXCESS LOSS SCHEDULE

If this "Excess Loss Schedule" is approved by us, it will be attached to the Excess Loss Insurance Policy (hereinafter referred to as "policy"). By way of this "Excess Loss Schedule", application is made for a "policy" as specified herein. Terms used herein are as defined in the "policy".

POLICYHOLDER (hereinafter referred to as "you", "your") **– MAIN MAILING ADDRESS**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Subsidiary or affiliated companies to be included (list legal names and addresses):

Name			Name		
Address			Address		
City	State	Zip Code	City	State	Zip Code

SIC/Industry Description: _____ State of Jurisdiction: _____

POLICY NUMBER (issued upon acceptance of this "Excess Loss Schedule"): _____

"Policy Period" Effective Date: _____ Expiration Date: _____
(dates are as of 12:01 a.m. local time at your main mailing address shown above)

ADMINISTRATOR

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

A. SPECIFIC EXCESS LOSS INSURANCE

Minimum Number of Full Time Employees: _____

1. Benefits Covered:
   ❑ Medical ❑ Prescription Card ❑ Dental ❑ Vision ❑ Other _____

2. "Benefit period" shall consist of the following "incurred" and "paid claims" bases:

   "Eligible expenses" which are "incurred" from _____* to _____*; and
   "Eligible expenses" which are "paid claims" from _____* to _____*
   (*dates are as of 12:01 a.m. local time at your main mailing address shown above)

3. "Specific deductible": $_____ (minimum of $_____) per "eligible person" for all occurrences. Except for the following:

   _____ : $_____
   _____ : $_____
   _____ : $_____

4. Specific "benefit percentage" _____% (maximum 100%)

5. Specific benefit limit $_____ per ❑ "policy period" ❑ lifetime, per "eligible person"

6. ❑ "Run-In Limit" / ❑ "Run-Out Limit": $_____

7. Monthly Specific Premium Rate and "Covered Units":

	Rate:	"Covered Units":	
Single/Employee	$_____	Single/Employee	_____
Family/Dependent	$_____	Family/Dependent	_____
Composite (Single and Family)	$_____	Total	_____

8. Deposit of $_____ is enclosed to apply to the first payment under this "policy", if issued, subject to the **CONDITIONS** noted in section **E.** If not accepted, the deposit will be returned.

B. AGGREGATE EXCESS LOSS INSURANCE

1. Benefits Covered:

   ❑ Medical ❑ Prescription Card ❑ Dental ❑ Vision ❑ Other _____

2. "Benefit period" shall consist of the following "incurred" and "paid claims" bases:

   "Eligible expenses" which are "incurred" from _____* to _____*; and
   "Eligible expenses" which are "paid claims" from _____* to _____*
   (*dates are as of 12:01 a.m. local time at your main mailing address shown above)

3. Maximum "eligible expenses" per "eligible person" accumulating toward the Aggregate Excess Loss Insurance $_____.

4. "Minimum aggregate attachment point": $_____ or _____% of the first "monthly aggregate attachment point" x ____ months, whichever is greater.

5. Aggregate "benefit percentage": _____%

6. Aggregate benefit limit: $_____

7. ❑ "Run-In Limit" / ❑ "Run-Out Limit": $_____

8. Monthly Aggregate Factors and "Covered Units":

	Factors:	"Covered Units":	
Single/Employee	$_____	Single/Employee	_____
Family/Dependent	$_____	Family/Dependent	_____
Composite (Single and Family)	$_____	Total	_____

9. Aggregate premium ❑ Annual ❑ Monthly $_____

C. OPTIONS

	Yes	No	
1. "Actively at Work" waived?	❑	❑	
2. Retired employees and dependents covered?	❑	❑	If yes, limited to: $_____
3. Drug or Alcohol Abuse covered?	❑	❑	If yes, limited to: $_____

D. FRAUD NOTICE

NOTE: If your state requires a fraud notice that differs from the language below, the state-specific language will be attached to this "Excess Loss Schedule" as a rider (form EAH 01 513), and the language of that rider replaces the language below.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

E. CONDITIONS

As conditions precedent to the approval of this "Excess Loss Schedule":

1. You shall furnish to us, for our approval, a copy of the "plan document" describing the benefits provided by you. No "policy" will be released or claim reimbursed until such time as an acceptable "plan document" is received and approved by us. In the event of a variance between the "plan document" received by us and the terms of the Excess Loss Insurance upon which such Excess Loss Insurance was based, we reserve the right to revise the premium rates, factors, terms and/or conditions. We may decline to release the "policy" until such time as you provide written acceptance of the revisions, if any;

2. The dated "Disclosure Statement", experience, census and other information provided by you, directly or through your "administrator", are primary data elements on which our proposal is based. In accepting the "policy", you represent that, to the best of your knowledge and belief, such information is true;

3. The receipt by us of any sum(s) referenced herein and the deposit of any check drawn in connection with this "Excess Loss Schedule" shall not constitute an acceptance of liability by us. In the event we do not approve this "Excess Loss Schedule", our sole obligation shall be to refund such sum(s) to you, and;

4. You understand and agree: (1) the Excess Loss Insurance applied for shall not take effect until such insurance has been approved by us and accepted as confirmed by delivery of the "policy" to you, or to your "administrator"; (2) the "plan document" attached and referred herein shall be the basis of the "policy" issued by us and such "plan document" conforms with applicable State and Federal statutes; and (3) any reimbursement shall be determined in accordance with the "plan document" and the "policy" that is the subject of this "Excess Loss Schedule".

5. NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

F. FORMS AND RIDERS

YOUR ACCEPTANCE **ADMINISTRATOR'S ACCEPTANCE**

Name of Your Officer (printed)	Federal Tax ID #	Name of Administrator's Officer (printed)	License #
Signature & Title of Your Officer		Signature & Title of Administrator's Officer	
Witness of Officer signing for You	Date	Witness of Officer signing for Administrator	Date

SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*EVST-125727629*	*State:*	*Arkansas*
Filing Company:	*Everest National Insurance Company*	*State Tracking Number:*	*39559*
Company Tracking Number:	*AR-AH-20024410-EN*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*A&H*		
Project Name/Number:	*Excess Loss Schedule/AR-AH-20024410*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 07/09/2008
Comments:
Attachment:
FLESCH CERTIFICATION.pdf

Bypassed -Name: Application
Review Status: Approved-Closed 07/09/2008
Bypass Reason: NA
Comments:

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 07/09/2008
Bypass Reason: NA
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 07/09/2008
Bypass Reason: NA
Comments:

Everest National Insurance Company/Everest Reinsurance Company

FLESCH CERTIFICATION

Re: Form(s)EDEC 642 04 08

I, Reid Bellanca of the Everest National Insurance,

Hereby certify that, above schedule has achieved a flesch score of 46.1.

Officer's Signature

7/9/2008
Date

Vice President
Title

reid.bellanca@everestre.com
e-mail address

(908) 604-3394
Telephone number

477 Martinsville Road
Mailing address

Liberty Corner, NJ 07938-0830
City, State, Zip